

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

Registrar's No. 940036630

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

STATE FILE NUMBER

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

PLACE OF DEATH
a. COUNTY **ST. LOUIS**

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN **ST. LOUIS, MO**

Length of stay in 1b

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION **ST. LOUIS CITY HOSP #1.**

Inside Limits
Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE **MISSOURI** b. COUNTY

c. CITY
OR TOWN **ST. LOUIS**

Inside Limits
Yes ☐ No ☐

d. STREET
ADDRESS **2143 O'Fallon Apt. # 303**

Reside on Farm
Yes ☐ No ☐

3. NAME OF DECEASED
(Type or print)

First

Middle

Last

JAMES

ELLISON

4. DATE
OF DEATH

Month Day Year
OCT. 2, 1964

5. SEX
Male

6. COLOR OR RACE
Colored

7. Married ☒ Never Married ☐
Widowed ☐ Divorced ☐

8. DATE OF BIRTH
3-19-11

9. AGE (last birthday)
53 yrs.

IF UNDER 1 YEAR IF UNDER 24 HR
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer

10b. KIND OF BUSINESS OR INDUSTRY
None

11. BIRTHPLACE (City and state or country)
Tennessee

12. CITIZEN OF WHAT COUNTRY
U.S.A.

13a. FATHER'S NAME

Thomas Ellison

13b. MOTHER'S MAIDEN NAME

Nora Crist

14. NAME OF HUSBAND OR WIFE

Gladys Ellison

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)
No

16. SOCIAL SECURITY NO.
None

17. INFORMANT

Gladys Ellison-2143 O'Fallon Apt. #303

18. CAUSE OF DEATH (Enter only one cause per line)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CONGESTIVE HEART FAILURE

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

RHEUMATIC HEART DISEASE (INACTIVE)

DUE TO (c)

4/6X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY
Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from **9/21/64** to **10/2/64** and last saw her alive on **10/2/64**
Death occurred at **10:AM** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Registree or title)

Donald K. Bach, M.D.

22b. ADDRESS

1515 LAFAYETTE AVE

22c. DATE SIGNED

10/2/64

23a. BURIAL, CREMATION, REMOVAL (Specify)

Removal

23b. DATE

10-6-1964

23c. NAME OF CEMETERY OR CREMATORY

Greenwood Cemetery

23d. LOCATION (City, town, or county)

St. Louis (County) Missouri

24. FUNERAL DIRECTOR

ADDRESS

Ellis Funeral Home-2820 Stoddard St.

25. DATE RECD. BY LOCAL REG.

OCT 6 1964

26. REGISTRAR'S SIGNATURE

Don Smith, M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Raymond Dickson

Licensed Embalmer No. 5218

P. O. Address 2820 Stoddard

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.